



## Medicaid Advisory Committee *Meeting Minutes* November 17, 2016

### **Members Present**

*Chairperson Matthew Brooks, Medicaid Director Joe Moser, Dr. Leila Alter, Herb Hunter, Blayne Miley, Ted Danielson, Randal Seals, Michael Colby, Brian Hart, Terry Cole, Rodney King, Senator Patricia Miller, Michael Rinebold, Jason Kolkmeier, Jon Thompson, Kevin Moore*

### **I. Opening Comments**

Chairperson Matt Brooks opened the meeting of the Medicaid Advisory Committee (MAC). He welcomed the members and guests.

### **II. Review of Minutes – August 25, 2016**

Chairperson Brooks asked the committee if they have reviewed the August 25, 2016 draft meeting minutes. Mr. Brooks then asked for any additions, changes, or deletions. Hearing none, he motioned for approval. The minutes were approved by unanimous consent.

### **III. MAC Updates**

Chairperson Brooks announced the MAC meetings for 2017 as:

February 24, 2017	1:00pm -3:00pm in Conference Room C
May 25, 2017	10:00am -12:00pm in Conference Room C
August 24, 2017	1:00pm -3:00pm in Conference Room C
November 16, 2017	10:00am -12:00pm in Conference Room C

### **IV. CoreMMIS Implementation**

Deputy Medicaid Director Shane Hatchett stated that the *CoreMMIS* and Provider Healthcare Portal has been a four year project to update the Medicaid enterprise system and will replace *IndianaAIM* and *Web interChange*. The Provider Healthcare Portal will have more self-service features available. Enhancements include allowing providers to upload documents instead of faxing for prior authorizations and claims, online enrollment, and more. Providers will need to familiarize themselves with the new eligibility screens as they are changing significantly from what providers are familiar with today. Deputy Director Hatchett said that testing continues in order to mitigate risks. FSSA staff are working with Hewlett Packard Enterprise along with other partners to minimize disruption and impacts, but that some suspension of business will occur as outlined in previous bulletins. During the transition there will be updated billing guidance published to ensure claims are paid correctly. Deputy Director Hatchett said there will be training available online and at the annual seminar on how to use the new portal, along with live webinars to assist with portal registration, viewing eligibility, and submitting claims. Post-implementation there will



be efforts focused on stabilizing the system and preparing for CMS certification. There will be daily touchpoints with associations and partners to track major issues and provide updates.

#### **V. Hoosier Healthwise Open Enrollment**

Ms. Vickie Trout, OMPP Quality and Outcomes Section Director, stated that when determining what would be best for members and the Managed Care Entities (MCEs) when the CareSource contract starts on 1/1/17, OMPP felt it important to give choices to Medicaid members to choose amongst all the available plans. Vickie stated that Indiana Medicaid has awarded four contracts to MCE's: Anthem, MDWise, MHS, and CareSource. Ms. Trout stated that to give members choice, they were provided a special open enrollment for Hoosier Healthwise members for the option to choose another MCE. Ms. Trout stated that in order to have open enrollment, they needed to ensure the four MCE plans were ready to start implementing their 2017 contracts, in which their readiness was deemed by the readiness review performed by the Office of Medicaid Policy and Planning team. Although all Hoosier Healthwise members are given the option to choose a new health plan during their special open enrollment period, if the member is satisfied with their current health plan they do not need to do anything. Ms. Trout stated that if a member wanted to change their health plan then they needed to get in touch with Maximus, who is the enrollment broker, to make changes to their health plan. Maximus can also provide a side-by-side view of their current health plan and another health plan to help the member make their decision of if they would like to change plans. If a Hoosier Healthwise member wants to make a change to their health plan then it needs to be completed by the last day of open enrollment, December 15, 2016.

#### **VI. Medicaid Provider Audit Workgroup Update**

Deputy Medicaid Director Shane Hatchett presented an update on the Provider Audit Workgroup. He stated that the workgroup was established by SEA 354-2016 and is composed of Medicaid Advisory Committee members and Managed Care Entity Representatives. The workgroup's duty was to review the provider audit processes. There have been three workgroup meetings along with three public hearings in Indianapolis, Evansville, and Mishawaka. During the public hearings there were sixty-two attendees with fourteen verbal testimonies and four written testimonies submitted. The key findings from the providers' comments and workgroup discussion were the look back period, the audit methodology, communications and transparency, and provider education. A draft of the final report was posted online for workgroup input and, excepting technical corrections, the final report was unanimously adopted at the September 26, 2016 workgroup meeting. The workgroup requested agency response within 30 days. The agency's response to the final report was that the lookback period would be reduced to 3 years excepting fraud and retention requirements, the audit methodology will be enumerated in policy and rules to improve transparency and FSSA will review education requirements of contractors to ensure the most appropriate professionals are auditing providers. The final report is due to the legislature by December 1, 2016.

## **VII. Presumptive Eligibility Compliance**

The Presumptive Eligibility Manager, Ray Evers, gave a presentation on presumptive eligibility compliance. During this presentation Mr. Evers stated that the qualified provider responsibilities were to verify individuals IHCP eligibility via the Web Interchange, Automated Voice Response, or Electronic Data Interchange. Qualified PE providers are responsible for making presumptive eligibility determinations consistent with state policies and procedures, guiding PE enrolled individuals to complete the Medicaid application within 30 days of their PE application, affirm that the organization understands and abides by any published guidance regarding performance of PE activities, and affirm that the organization will not knowingly misrepresent client's information. The Hospital Presumptive Eligibility performance management compliance timeline is to review current performance in a baseline review period of April-June 2016. Once they have reviewed current performance then they will notify the qualified provider and give them a goal they must meet in the next review period October-December 2016. The data from the second review period will determine who needs to be placed on a corrective action plan (CAP) to improve their performance within the next 90 days. Finally, Mr. Evers noted that there will be Quarterly Stakeholder group meetings to review data and discuss any issues in the HPE program. Stakeholders include the Indiana Hospital Association, Indiana Council of Community Mental Health Centers, Indiana Primary Health Care Association, ClaimAid, and Covering Kids and Families.

## **VIII. FSSA Updates**

Director Moser stated that last year Indiana Medicaid announced a change in policy to allow nurse practitioners to have primary care panels and be primary care providers, in addition to physicians. The limitation that Indiana Medicaid has on physician panel sizes was 2,500 members per physician and the nurse practitioner panel size that was started in January 2016 was limited to 500 Medicaid members per practitioner. Upon further review of the policies, Indiana Medicaid has made the decision to eliminate state mandated panel sizes altogether effective immediately. This will be communicated via a provider bulletin. MCEs may adopt their own panel sizes as they deem appropriate.

There was a policy request asking that physician assistants be eligible to enroll as providers in the Indiana Medicaid program, which would allow them to be listed as providers on the Medicaid website but would not change any of the billing or reimbursement practices. Allowing them to enroll in the Medicaid program will help Medicaid better track who is providing care to our members. This will go in to place later in 2017, but the date is not yet determined. Director Moser stated that this will provide better access to care for Medicaid members.

The new federally required fingerprinting standards will be put into place with high risk providers in the Indiana Medicaid program and they will need to be completed by April 1, 2017.

Director Moser stated that the Providers Relations Director, Tatum Miller, will be leaving the Office of Medicaid Policy and Planning on January 6, 2017 and OMPP will be filling the Director of Provider Relations position upon her departure.

Chairperson Brooks thanked Senator Patricia Miller for serving on the Medicaid Advisory Committee over the years and congratulated her on her retirement.

**IX. Public Comments**

There were no public comments.

**X. Next MAC Meetings**

Special MAC Meeting – Public Hearing: Tuesday, January 5, 2017 1:00pm -3:00pm  
IGCS; IN State Library History Reference Room

MAC Meeting: Friday, February 24, 2017 1:00pm -3:00pm IGCS; Conference Room C